COMPREHENSIVE MEDICAL & DENTAL PROGRAM

PROVIDER REVIEW

Department of Economic Security,
Comprehensive Medical and Dental Program

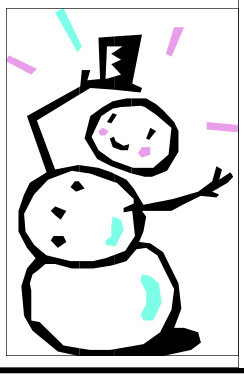
Volume 6, Issue 4 December 2006

CMDP Website:
www.azdes.gov/dcyf/cmdpe

A Special Thank You from CMDP.....

As this is the last "Provider Review" for 2006, I would like to take this opportunity to thank all of our health care providers for the consistent high quality service you have delivered to Arizona's children in Foster Care. These children and those involved with the foster care system rely upon your expertise and compassion to assist them throughout the year. I wish you all a joyous holiday season and a happy and prosperous new year.

Thank you!
Tim Newton,
Program Administrator



Anna Binkiewicz, M.D. is honored by CMDP with Lifetime Achievement Award

Dr. Anna Binkiewicz was honored with the Lifetime Achievement Award given by the Comprehensive Medical and Dental Program, part of the Division of Children, Youth and Family with The Department of Economic Security in October 2006 at the *Annual Children Need Homes Conference*.

Dr. Binkiewicz completed her Internship and Residency at Boston Floating Hospital, Boston, Massachusetts. In addition, she completed two fellowships: one in Emotional and Social Aspects in Pediatrics and another in Pediatric Endocrinology, both were done in Boston, MA. Dr. Binkiewicz has been a Professor of Clinical Pediatrics since 1986 at the University of Arizona College of Medicine. She has been the Medical Director of Casa de los Niños Crisis Nursery in Tucson, AZ since 1988.

Her professional career focused on the care of children and youth who were victims of child abuse and neglect. Dr. Binkiewicz was able to secure grant funding for multiple projects related to child abuse and the substance-abused newborn, resulting in improvements in reporting and follow-up care for this population. Dr. Binkiewicz has had over twenty articles published in medical literature. She has done countless presentations and lectures many focusing on trainings for the Department of Economic Security Child Protective Services case managers and pediatric interns and residents with a focus on Failure To Thrive and related physical neglect issues, child abuse, the substance exposed newborn, child abuse in children with disabilities, and shaken baby syndrome; etc.

Over the past 20 years, Dr. Binkiewicz has provided care to many CMDP babies at Casa de los Niños Crisis Nursery. Her committee and community involvements has included: Member of Governor's Task Force for The Prevention of Child Abuse in Arizona; Member of Arizona Council for Mothers and Children; Founder of Child Advocacy Group in the Department of Pediatrics at the University of Arizona Health Sciences Center, member since 1987; and participant with Pima County Multidisciplinary Team for Review of Suspected Child Abuse Cases. Her past awards have included: Recipient of Award for Professional Excellence from the Arizona Chapter of NCPCA, Recipient of the Ray E. Helfer, M.D. Award given by the National Alliance of Children's Trust and Prevention Funds and the American Academy of Pediatrics' Section on Child Abuse.

What is Cultural Competency?

Cultural competency requires effectively providing services to people of all cultures, races, ethnic backgrounds and religions in a manner that respects the worth of individuals and preserves their dignity. It requires that organizations have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally.

It has long been acknowledged that a patient's health beliefs and communication style play critical roles in medical care. The issues of cross-cultural communication and variations in health beliefs not only impact patient satisfaction, but can also impact clinical outcomes.

1. Awareness of self and one's own value system;

- How do I react when a patient does not speak English?
- What are my beliefs toward folk remedies?

2. An Understanding of the concept of culture and its role as a factor in health and health care.

- Is there anything about your cultural beliefs that I should be aware of when providing you with healthcare?

3. A sensitivity to cultural issues for each patient.

- In order to provide a more effective medical treatment, it is vital to inquire about a patient's:
  - native language
  - influence of religion/spirituality
  - family relationships
  - communication style
  - health practices
  - illness beliefs
  - relationship with health care provider

Sociocultural Barriers to US Healthcare

People of diverse racial and ethnic minority groups face substantial barriers to care such as language and communication barriers, medical practices that differ from their own beliefs and traditions, fear and mistrust of health care institutions, and a lack of knowledge about how to navigate the system.

These sociocultural barriers can lead to difficulty in scheduling an appointment, misunderstandings between clinicians and patients, misdiagnoses and poor follow through on the patient's behalf. Sociocultural barriers to health care are created by differences between patients and providers in areas such as: Language and nonverbal communication, Health practices and beliefs; The role of family members in health care decision-making; Patient knowledge and expectations of the health care system, and the culture and complexity of the health care system.

U.S. Food and Drug Administration
Center for Drug Evaluation and Research, October 2006

October 6, 2006: The FDA has approved Risperdal (risperidone) for the symptomatic treatment of irritability in autistic children and adolescents. This is the first approval for use of a drug to treat behaviors associated with autism in children. Behaviors such as aggression, deliberate self-injury and temper tantrums are considered under the umbrella of irritability.

October 6, 2006: The FDA relaxed some requirements for iPledge, a risk management program to reduce the risk of fetal exposure to oral isotretinoin (Accutane). Males and females of non-child bearing potential (FNCBP) will no longer have the 23 day lock-out period that was previously required. Previously, all patients prescribed isotretinoin had to fill their prescription within 7 days of the office visit/ prescription being written. If they tried to fill after 7 days, they had to wait another 23 days, to prevent the likelihood of taking the drug during pregnancy.

September 29, 2006: The FDA issued a preliminary alert for Lamictal. New information suggests babies exposed to Lamictal (lamotrigine) during the first 3 months of pregnancy may have a higher chance of being born with a cleft lip or cleft palate. Lamictal is used for seizures and bipolar disorder. More research is needed and the FDA is still considering the data before making a final conclusion.

September 20, 2006: The FDA announced updates to Ortho Evra's label after studying electronic health claims data from two studies. One of the studies found an increased risk of blood clots for Ortho Evra users over oral contraceptives. The other study did not find an increased risk.

September 11, 2006: The FDA approved the first time generic for Topamax, topiramate in 25mg, 100mg and 200mg strengths for the treatment of epilepsy.

September 8, 2006: The FDA issued a Healthcare Professional Sheet about using ibuprofen with aspirin. Ibuprofen can interfere with the anti-platelet effect of low-dose aspirin, making it less effective in preventing blood clots and stroke.

August 24, 2006: The FDA approved PlanB, an emergency contraceptive, for use over-the-counter in women ages 18 and older. PlanB will be stocked by pharmacies behind the counter to ensure it is not dispensed without a prescription or proof of age. The manufacturer is still revising the packaging but plans to release the product by the end of the year.

Updates:
Albuterol inhalers will not be available in the near future; they will be changing to Proventil HFA inhalers. Supply issues are already being noted. More information will be coming.

NPI: Get It. Share It. Use It.

Only 7 months remain until the National Provider Identifier (NPI) compliance date. Over 1,300,000 NPI's have been issued so far -- do you have your NPI yet?

Act Now!

Don't procrastinate; getting your NPI is only the first step in preparing for the compliance date. You should allow time to share your NPI with payers and other trading partners, update your referral lists, as well as modify and test computer systems.

Resources for Commonly Asked Questions

CMS has compiled a list of resources that will help to answer many questions on NPI. Visit http://www.cms.hhs.gov/NationalProvIdentStand/07_Questions.asp#TopOfPage to view this resource. Additionally, CMS continues to build its database of Frequently Asked Questions (FAQs) on NPI. Recently an FAQ on Electronic File Transfer (EFT) of payments from health plans to health care providers was added. You can view all existing NPI FAQs at http://questions.cms.hhs.gov on the CMS website.

*****Special Information for Medicare Providers*****

Billing Medicare

Medicare is testing the new software that has been developed to use the National Provider Identifier (NPI) in the existing Medicare fee-for-service claims processing systems. **Providers have until May 23, 2007 before they are required to submit claims with only an NPI.**

Until testing is complete within the Medicare processing systems, Medicare urges providers to continue submitting Medicare fee-for-service claims in one of two ways:

- Use your legacy number, such as your Provider Identification Number (PIN), NSC number, OSCAR number or UPIN; or
- Use both your NPI and your legacy number.

Until testing of the new software that uses the NPI in the Medicare systems is complete and until further notice from Medicare, the following may occur if you submit Medicare claims with only an NPI:

- Claims may be processed and paid, or
- Claims for which Medicare systems are unable to properly match the incoming NPI with a legacy number (e.g., PIN, OSCAR number) may be rejected to the provider, and then you will need to resubmit the claim with the appropriate legacy number.

Required Use of NPI on Medicare Paper Claim Forms

Medicare will require the NPI on its paper claim forms. A variety of MLN Matters articles are available on this topic at http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/MMArticles_npi.pdf on the CMS NPI web page.

How to Share Your NPI with Medicare

Medicare providers may share their NPIs with Medicare in three different ways:

- For new Medicare providers, an NPI must be included on a CMS-855 enrollment application.
- Existing Medicare providers must provide their NPIs when making any changes to their Medicare enrollment information.
- Medicare providers should use their NPI, along with appropriate legacy identifiers, on their Medicare claims.

Still not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI can be found at the CMS NPI page www.cms.hhs.gov/NationalProvIdentStand on the CMS website. Providers can apply for an NPI online at https://nppes.cms.hhs.gov or can call the NPI enumerator to request a paper application at 1-800-465-3203.

Getting an NPI is free - not having one can be costly.

PEDS Tool

Thank you for your interest in training to use the Parent's Evaluation of Developmental Status (PEDS) Tool. Through a recommendation by the Arizona Chapter of the American Academy of Pediatrics, AHCCCS has chosen this validated screening tool for use in screening young children for developmental delays and disabilities. AHCCCS has recognized the additional work necessary to incorporate this tool into routine EPSDT visits by adding a payment of $29.70 for its use.

Please bill using code: 96110 with an EP modifier.

To evaluate the efficacy of using the tool in an office setting, as well as the accessibility of referral services, payment for the use of the PEDS Tool will be limited to those infants born after January 1, 2006 who have had stays in the Newborn Intensive Care Unit. (NICU) and for **CMDP members only.** The tool may be used to screen infants and children (up to the age of 8), who are at-risk or identified as having developmental delays. These children may be screened at each EPSDT visit. Providers who bill for this service must demonstrate that they have completed a brief training on the use of the tool and must submit the PEDS Tool Score Form and the PEDS Tool Interpretation Form with the EPSDT for reimbursement of services.

Training:

You and your staff can utilize an on-line PEDS Tool training session on the www.azaap.org website under the PEDS heading. This will trigger AzAAP to alert AHCCCS and the AHCCCS health plans that you have completed the training. After completion you may start to bill CMDP for use of the tool.

Information on the PEDS Tool and how to order hard copies of the PEDS tool for use in your office or clinic is available on-line at www.pedstest.com or www.forepath.com. Providers should be aware that making photocopies of the PEDS tool is a violation of copyright law. The cost of the tool as well as the time to administer the tool has been accounted for by AHCCCS in the reimbursement. Providers will be required to submit photocopies of the PEDS score and interpretation form to CMDP in the same manner that the EPSDT forms are currently submitted.

If you should have any questions or concerns please contact Sandra Davis, R.N. at (602) 351-2245 or (800) 201-1795.

Are you completing your EPSDT form?

CMDP recognizes the importance of EPSDT visits for the health and well being of its special needs population. This is of particular concern for the CMDP member population, which is a discreet population of children in foster care that may not have had adequate health care in their early years due to the lack of parental involvement. The Child Welfare Reporting Requirements in Arizona for 1 Oct 05 through 31 March 06, indicate that there were over 17,756 reports made to CPS during this period, and that the greatest reason for removal from the home (60%), involved neglect.

Review of the medical literature reveals that 29% of preschool and 55% of school-aged children in foster care have borderline or retarded mental development. Language disorders, fine motor delays, poor social adaptive skills, learning disabilities, limited cognitive ability and behavioral disorders are more commonly seen in the foster population. Forty percent (40%) of children in foster care qualify for special education services.

Behavioral health issues are very common in the foster care population. It is the most common overall health problem reported in 85% of children in foster care. Moderate to severe mental health disorders are seen in 70% of these children and adolescents!

A recent publication titled *Comprehensive Assessments for Children Entering Foster Care: A National Perspective* by Leslie KL, et.al. in the July issue of Pediatrics 2003; 112(1): 134-142 concludes that 94% of comprehensive assessments include screening children entering foster care for physical health problems, however, less than 43% of assessments included developmental and mental health evaluations.

Ensuring that children in foster care receive appropriate Developmental and Behavioral Health Screenings is an important aspect of addressing the children's overall well-being and health care needs. The decision to focus on the quality of EPSDT visits for children who are CMDP members is based upon the importance of a complete EPSDT visit and meeting the health care needs of the special population served by CMDP. **Routine review of EPSDT forms reveals a lack of compliance in completing and/or documenting Developmental and Behavioral Health Screens. CMDP encourages its providers to complete and document these vital aspects of the EPSDT.**

EPSDT EVALUATIONS

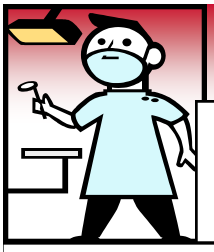
When doing an EPSDT evaluation on your patients it is imperative that you document all age appropriate screenings that were completed; specifically, developmental screenings and behavioral health screenings. One of the criteria CMDP measures is whether or not the screenings are being completed. You may in fact be doing these, but unless you mark the appropriate box on the EPSDT form you will not obtain credit for doing them. CMDP is currently working on a Performance Improvement Project (PIP) that measures how many developmental screenings and behavioral health screenings are being completed in accordance with AHCCCS rules and regulations. We urge you to be diligent in documenting your work. We want to make sure you get credit for the work you <u>are</u> doing and the only way this is going to happen is if you document, document, document. Please, it only takes a couple of seconds to mark the appropriate box which will allow us to prove that our children are receiving proper and thorough EPSDT screenings. In addition, please be aware that you are **not** to use the EPSDT forms for "<u>sick child</u>" visits or visits other than an actual EPSDT visit. **You may not bill** for an EPSDT visit just because you use the EPSDT form. The EPSDT form may be used and billed as an EPSDT visit only when you are performing an EPSDT service. When performing an EPSDT service on a well child the evaluation must include Behavioral Health and Developmental screenings. CMDP would like to thank you in advance for your cooperation in this matter and as always we look forward to working with you to provide the best care possible for our CMDP kids.

Immunizations: Are they current?

Recently it has come to our attention that on the EPSDT form, under Immunization Assessment, the box indicating that there is a current immunization record available in the members medical chart is often left blank or marked no. It is imperative that all of our CMDP members have an accurate accounting of all immunizations that they have received. Usually we find out after mailing you a list of members we have identified by the EPSDT forms that don't have current records, that immunization records do exist in the medical file. CMDP tracks all immunization activity. Please give yourselves credit for what you do so that we won't have to have you do additional research to verify that the records exist. This will save time for both you and your staff as well as giving you the credit you deserve .

If you find that you do not have a current immunization record available, please start one. You can connect with the ASIIS Registry to find out about what immunizations have already been given and what has yet to be given. We need to make sure all of our members are properly immunized, but we don't want to repeat immunizations if it is not necessary.

CMDP wishes to thank all of you for helping us to protect the health and well being of our members and we look forward to working cooperatively with you.



DR. C SAYS……

"IMPORTANCE OF ORAL HEALTH DURING PREGNANCY"

BY DR. JERRY CANIGLIA, DENTAL CONSULTANT

It is during pregnancy that women would be particularly willing to focus on disease prevention and health promotion interventions that could enhance her own health or that of her infant. Recently, the dental community has brought attention to the potential associations between periodontal (gum) disease and pregnancy outcomes.

Recent studies have shown that periodontal disease conditions, a reservoir for inflammatory agents, are potential threats to the placenta and fetus. The data suggests that these inflammatory agents may increase the likelihood of miscarriages and preterm births. Additional investigations of preterm low birth weight babies, have shown that the presence of maternal periodontal infections is likely a contributing risk factor and clinically significant.

Attention toward the oral health needs of pregnant women is of great importance. Dental and medical professionals should inform women of childbearing age to have a thorough periodontal assessment and necessary dental care. Utilizing a preventive health approach will benefit maternal oral health and potentially decrease adverse prenatal outcomes.

UPDATE on PIP 2005, Study of Inappropriate ER Utilization

CMDP completed the first year of our Inappropriate ER Utilization Performance Improvement Project (PIP). After thoroughly reviewing all of the ER notifications from October 2004 to September 2005, sufficient data was gathered to identify some significant trends and factors:

- The top five reasons for non-emergent ER visits were Cough/Cold, Bump/Minor/General Pain, Vomiting/Diarrhea, Misc/Other, and Rashes/Bug Bites.
- Of the non-emergent ER Visits identified, 44% occurred in Pima County, 32% in Maricopa County, and 24% in the other remaining counties.
- 62% of the children that had non-emergent ER visits were in a Group Home or Kinship/Relative placement.

The above information has helped CMDP propose some strategies and interventions that were implemented from October 2005 through September 2006. **You, the Primary Care Physicians and Specialists, can also play a role by encouraging members to come to your office for routine care, and to use the Emergency Room only during the hours that your office is not open and only for TRUE Emergency Care.** In addition, if you identify a member that is frequently using the Emergency Room for non-emergent reasons, please feel free to contact CMDP and ask to speak with a Care Coordinator. CMDP Care Coordinators can provide education or of an individual basis.
Thank you for your continued care and commitment of CMDP's special needs children.

ASIIS

CMDP needs your help in keeping the ASIIS system updated. The ASIIS system as you know is the statewide immunization records keeping system. According to Arizona Revised Statute 36-135 it is mandated that all physicians record immunizations given to all children ages "birth through 18 years" in the ASIIS system. This only takes a few minutes and can prevent a child from being needlessly re-immunized because his/her immunization history is not known. This is particularly true of CMDP's population of foster children because they change placements often and their immunization records do not always accompany them. ASIIS is often the only way we can track records of these children.

ASIIS can be of great help to you in your practice. Not only can you find out about the immunization histories of your patients, but you can also print out forecasts of what immunizations are due and the time frame in which they need to be given. These can be given to the children's parents or guardians who can then partner with you in making sure their children are immunized. In addition to the regular immunizations, you can also track flu, pneumonia, PPD testing and results and much more. It is a user-friendly system and available to every physician's office.

When you are entering a new record on a foster child please put in DES for the name of the parent/responsible party and CMDP in for the name of the Health Plan and under phone number put (602) 351-2245. This helps to prevent duplication of records when the foster parent's name changes. **If you do find a duplication of records please contact Richard Bradley at ASIIS at rbradle@hs.state.az.us, give him the numbers of the entries and he will merge the records.**

CMDP cannot emphasize enough the importance of keeping the ASIIS system updated. Please have your office staff do this routinely. If they do not have access to the system , need a sign-on, or training this can all be done through Richard Bradley at the above e-mail address. CMDP is depending on you to partner with us in keeping our children's immunizations up-to-date and we thank you for all of your efforts in helping us to keep our children healthy!

INFLUENZA VACCINES

The inactivated influenza vaccine and LAIV can be used to reduce the risk for influenza virus infection and its complications. TIV is Food and Drug Administration (FDA)-approved for persons aged ≥6 months, including those with high-risk conditions, whereas LAIV is approved only for use among healthy persons aged 5--18 years.

Persons at Increased Risk for Complications

Vaccination with **inactivated influenza vaccine** is recommended for the following persons who are at increased risk for severe complications from influenza:

- children aged 6--23 months;
- children and adolescents (aged 6 months--18 years) who are receiving long-term aspirin therapy and, therefore, might be at risk for experiencing Reye syndrome after influenza virus infection;
- women who will be pregnant during the influenza season;
- children who have chronic disorders of the pulmonary or cardiovascular systems, including asthma (hypertension is not considered a high-risk condition);
- children who have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunodeficiency (including immunodeficiency caused by medications or by human immunodeficiency virus [HIV]);
- children who have any condition (e.g., cognitive dysfunction, spinal cord injuries, seizure disorders, or other neuromuscular disorders) that can compromise respiratory functions or the handling of respiratory secretions or that can increase the risk for aspiration;
- residents of nursing homes and other chronic-care facilities that house persons of any age who have chronic medical conditions.

Vaccination with **inactivated influenza vaccine** also is recommended for the following persons because of an increased risk for influenza-associated clinic, emergency department, or hospital visits, particularly if they have a high-risk medical condition:

- children aged 24--59 months

Additional Information Regarding Vaccination of Specific Populations:

Healthy Young Children Aged 6--59 Months

Because children aged 6--23 months are at substantially increased risk for influenza-related hospitalizations and because children aged 24--59 months are at increased risk for influenza-related clinic and emergency department visits, ACIP recommends vaccination of children aged 6--59 months. The current LAIV and inactivated influenza vaccines are not approved by FDA for use among children aged <6 months, the pediatric group at greatest risk for influenza-related complications. Vaccination of their household contacts and out-of-home caregivers also is recommended because it might decrease the probability of influenza virus infection among these children.

Studies indicate that rates of hospitalization are higher among young children than older children when influenza viruses are in circulation. The increased rates of hospitalization are comparable with rates for other groups considered at high risk for influenza-related complications. However, the interpretation of these findings has been confounded by cocirculation of respiratory syncytial virus that causes serious respiratory viral illness among children and that frequently circulates during the same time as influenza viruses. One study assessed rates of influenza-associated hospitalizations among the entire U.S. population during 1979--2001 and calculated an average rate of approximately 108 hospitalizations per 100,000 person-years in children aged <5 years. Two studies have attempted to separate the impact of respiratory syncytial viruses and influenza viruses on rates of hospitalization among children who do not have high-risk conditions. Both studies indicated that otherwise healthy children aged <2 years and possibly children aged 2--4 years are at increased risk for influenza-related hospitalization compared with older healthy children (Table 1). Among the Tennessee Medicaid population during 1973--1993, healthy children aged 6 months--2 years had rates of influenza-associated hospitalization comparable with or higher than rates among children aged 3--14 years with high-risk conditions. Another Tennessee study indicates a hospitalization rate per year of 3--4/1,000 healthy children aged <2 years for laboratory-confirmed influenza.

The ability of providers to implement the recommendation to vaccinate all children aged 24--59 months during the 2006--07 season the first year the recommendation will be in place might vary depending upon vaccine supply.

Live, Attenuated Influenza Vaccine (LAIV) Recommendations

LAIV is an option for vaccination of healthy, nonpregnant persons aged 5--18 years who want to avoid influenza, and those who might be in close contact with persons at high risk for severe complications, including health-care workers. During periods when inactivated vaccine is in short supply, use of LAIV is encouraged when feasible for eligible persons (including health-care workers) because use of LAIV by these persons might increase availability of inactivated vaccine for persons in groups at high risk. Possible advantages of LAIV include its potential to induce a broad mucosal and systemic immune response, its ease of administration, and the acceptability of an intranasal rather than intramuscular route of administration.

Claims Submission Timeframe

Timely filing is six months from the date of service. If a claim is denied for any reason the providers have 12 months from the date of service to **resubmit** a clean claim. Please correct the claim, **write resubmission on the envelope and if you have a stamp, stamp the claim resubmission. In addition w**www.azdes.gov/dcyf/cmdpe**e ask that you include the** denied **CRN number on the corrected claim.** Send the corrected claim and the EOB to P.O. Box 29202 Phoenix AZ. 85038-9202.

As a reminder –in most instances first time denials can be treated as resubmissions rather than filing grievances/disputes. However, we recommend that you do not let your deadlines for filing grievances/disputes expire.

***A "clean claim" is defined as a claim that includes all necessary documentation for adjudication and for which the initial submission is recei**www.azdes.gov/dcyf/cmdpe**ed within six (6) months from the date of service.**

CMDP Contacts: (602) 351-2245 (800) 201-1795

MEMBER SERVICES:
To verify a member's eligibility, chose any of these options:
****Please have member's name, date of birth, date of service & ID #.**
CMDP offers our providers eligibility verification via

- Phone (602) 351-2245, (800) 201-1795
- FAX (602) 264-3801
- Internet Website: www.azdes.gov/dcyf/cmdpe

Phone: Option 1 for English, Option 2 –if you are calling from a providers office, then Option 1

PROVIDER SERVICES:
Option 1, Option 2, then Option 3
For all your concerns, Provider Services will assist you or direct you to the appropriate department.

CLAIMS:
Option 1, Option 2 then Option 2
For verification of claim status, please select the options listed above for a claims representative.

CLAIMS MAILING ADDRESS:
CMDP 942-C, PO BOX 29202, PHOENIX, AZ 85038-9202

MEDICAL SERVICES:
Option 1, Option 2 then :

Hospitalizations……Option 7
Prior Authorizations:
Medical……Option 5
Dental……Option 4
Behavioral Health……Option 6
Pharmacy……Option 8

Please contact Medical Services with any questions regarding the medical needs of our members.

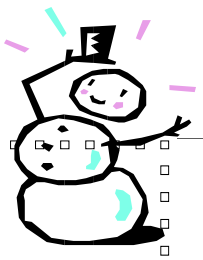
"Web Corner"

The following is a list of websites we recommend to assist your office. If there are any other websites you wish to add and share with other providers please contact Provider Services. We will add them to our next newsletter.

CMDP's Website: www.azdes.gov/dcyf/cmdpe
Your location for an updated:

- Provider Manual,
- Newsletters,
- Member Handbook,
- Preferred Medication List (PML)
- Forms
- Provider Directory
- Member Eligibility Verification
- Claims Status

UPDATED CAP FEE SCHEDULE, **AHCCCS Provider Manual** , EPSDT forms and more available at: www.azahcccs.gov
CHILDREN'S REHABILITATIVE SERVICES (CRS), information and referral forms: www.hs.state.az.us/phs/ocshcn/crs/index.htm
VACCINES FOR CHILDREN (VFC) Program: www.cdc.gov/nip/vfc/Provider/ProvidersHomePage.htm
Every Child by Two Immunizations: www.ecbt.org
ASIIS and TAPI: www.whyimmunize.org/us.htm
American Academy of Pediatrics: www.aap.org



Equal Opportunity Employer/Program. This document available in alternative formats by contacting Provider Services.